STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155756	A. BUILDING 01 B. WING	09/02/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 09/02/11 Facility Number: 004945 Provider Number: 155756 AIM Number: 200814400 Surveyor: Amy Kelley, Life Safety Code Specialist At this Life Safety Code survey, Coventry Meadows was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 18, New Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type V (111) construction and was fully	K0000		

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and resident rooms. The facility has a capacity of 150 and had a census of 142 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 09/09/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0038 SS=F	Exit access is arranged so that exits are readily accessible at all times in accordance with section 7.1. 18.2.1 Based on observation and interview, the facility failed to ensure the means of egress through 8 of 8 delayed-egress locks were readily accessible for all residents, staff and visitors. LSC 7.2.1.6.1, Delayed Egress Locks requires all approved, listed, delayed egress locks shall be permitted to be installed on doors serving low and ordinary hazard contents in buildings protected	K0038	The creation and submission of this Plan of Correction does not constitute an admission by this provider of any conclusion set forth in the statement of deficiencies, or of any violation of regulation. This provider respectfully requests that the 2567 Plan of Correction be considered the Letter of Credible Allegation. This facility respectfully requests a revisit on or after October 2, 2011.	10/02/2011

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	throughout by an approved, supervised automatic fire detection system installed in accordance with Section 9.6, or an approved, supervised automatic sprinkler system installed in accordance with Section 9.7, and where permitted in Chapters 12 through 42, provided: On the door adjacent to the release device, there shall be a readily visible, durable sign in letters not less than 1 inch high and at least 1/8 inch in stroke width on a contrasting background that reads: "PUSH UNTIL ALARM SOUNDS. DOOR CAN BE OPENED IN 15 SECONDS." This deficient practice could affect all occupants. Findings include: Based on observation with the Environmental Supervisor and the Maintenance Assistant on 09/02/11 at 12:41 p.m., the 100 hall exit door from the facility was provided with a delayed egress magnetic lock but the door was not provided with a sign. Based on an interview with the Environmental Supervisor at the time of observation, all exit doors		**K 038 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure that the Exit access is readily accessible at all times. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · All delayed egress doors (8 of 8) have a sign posted that states “Push Until Alarm Sounds. Door Can Be Opened In 15 Seconds”. The signs were posted on September 19 th , 2011. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · All delayed egress doors (8 of 8) have a sign posted that states “Push Until Alarm Sounds. Door Can Be Opened In 15 Seconds”. The signs were posted on September 19 th , 2011.	

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	from the facility were supplied with a delayed egress magnetic lock that would release in fifteen seconds when pressed. None of these exit doors were provided a sign. 3.1-19(b)		**What measures will be put into place or what systemic changes will you make to ensure that the deficient practice does not recur:** · All delayed egress doors (8 of 8) have a sign posted that states “Push Until Alarm Sounds. Door Can Be Opened In 15 Seconds”. The signs were posted on September 19 th , 2011. · The Maintenance Director will monitor all egress doors to ensure the signs are in place. · The Maintenance Director/Designee will in-service all managers to monitor egress doors to ensure the signs are in place. In-service will be completed by 10/2/11. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Egress Door Signs will be utilized every week x 4, monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI	

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			committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion Date: 10/2/2011**	
K0046 SS=E	Emergency lighting of at least 1½ hour duration is provided in accordance with 7.9. 18.2.9.1 Based on observation and interview, the facility failed to ensure 6 of 6 emergency light fixtures of at least 1½ hour duration were tested monthly and annually in accordance with LSC 7.9. LSC 7.9.3 Periodic Testing of Emergency Lighting Equipment requires a functional test shall be conducted on every required battery powered emergency lighting system at 30 day intervals for a minimum of 30 seconds. An annual test shall be conducted on every required battery powered emergency lighting system for not less than 1 ½ hour duration. Equipment shall be fully operational for the duration of the test. Written records of visual inspections and tests shall be kept	K0046	**K 046 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure all emergency lighting is provided for at least a 1 ½ hour duration. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · All emergency lighting was tested on September 20, 2011. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the	10/02/2011

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	by the owner for inspection by the authority having jurisdiction. This deficient practice could affect any occupants in the main entrance visitors restroom and the shower rooms on the 100, 200, 300, 400 and 500 halls. Findings include: Based on an observations with the Environmental Supervisor and the Maintenance Assistant on 09/02/11 from 12:35 p.m. to 2:15 p.m., battery operated emergency lights were observed in the visitors restroom near the main entrance and the in the 300 hall visitors restroom and the shower rooms of the 100, 200, 400 and 500 halls. Based on an interview with the Maintenance Supervisor at the time of observations, he was not aware of the battery operated lights and therefore no written records of a monthly test or an annual test regarding the battery operated emergency lights were available for review. 3.1-19(b)		alleged deficient practice. · All emergency lighting was tested on September 20, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur** · All emergency lighting was tested on September 20, 2011. · All emergency lighting was put on a monthly and annual test preventative maintenance schedule to be completed by the Maintenance Director/Designee. · The Maintenance Director/Designee will in-service Maintenance Assistant on the preventative maintenance schedule by October 2, 2011. · The Maintenance Director is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Emergency Lighting will be utilized every monthly x 3 and quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold is not met, an action plan will be	

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			developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 10/2/2011**	
K0056 SS=F	There is an automatic sprinkler system, installed in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems, with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. The system is maintained in accordance with NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems. There is a reliable, adequate water supply for the system. The system is equipped with waterflow and tamper switches which are connected to the fire alarm system. 18.3.5. Based on observation and interview, the facility failed to ensure complete coverage of the sprinkler system was provided for 1 of 1 communication rooms in accordance with NFPA 13, Standard for the Installation of Sprinkler Systems. The main fire alarm panel is located in the communication room so this deficient practice could affect all occupants. Findings include:	K0056	**K 056 NFPA 101 Life Safety Code Standard** It is the practice of this facility to have an automatic sprinkler system , installed in accordance with NFPA 13 with approved components, devices, and equipment, to provide complete coverage of all portions of the facility. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:**	10/02/2011

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	Based on observation with the Environmental Supervisor and the Maintenance Assistant on 09/02/11 at 12:55 p.m., the communication room located within the nourishment pantry was not provided with a sprinkler head. Based on an interview with the Environmental Supervisor at the time of observation, he stated a wall was constructed to make an enclosure for communication room. 3.1-19(b)		· A new sprinkler system is being added to the communication room by October 2, 2011. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All residents have the potential to be affected by the alleged deficient practice. · A new sprinkler system is being added to the communication room by October 2, 2011. **What measures will be put into place or what systemic changes you will make to ensure that the deficient practice does not recur:** · A new sprinkler system is being added to the communication room by October 2, 2011. · The new sprinkler system will be monitored and tested on an ongoing quarterly basis to ensure it is in working condition. · The testing will be documented in the preventative maintenance manual by the Maintenance Director/Designee. · The Maintenance Director	

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			is in charge of program compliance **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · The new sprinkler system will be monitored and tested on an ongoing quarterly basis to ensure it is in working condition · The testing will be documented in the preventative maintenance manual by the Maintenance Director/Designee. · A CQI monitoring tool called Sprinkler System will be utilized every quarter x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 10/2/2011**	
K0067 SS=F	Heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. 9.2, 18.5.2.1, 18.5.2.2, NFPA 90A Based on observation and interview, the facility failed to ensure an undetermined number	K0067	**K 067 NFPA 101 Life Safety Code Standard** It is the practice of this facility to	10/02/2011

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	of dampers were inspected and provided necessary maintenance at least every four years in accordance with NFPA 90A. LSC 9.2.1 requires air conditioning, heating, ventilating ductwork and related equipment shall be in accordance with NFPA 90A, Standard for the Installation of Air-Conditioning and Ventilating Systems. NFPA 90A, 1999 Edition, 3.4.7, Maintenance, requires at least every 4 years, fusible links shall be removed; all dampers shall be opened to verify they fully close; the latch, if provided, shall be checked, and moving parts shall be lubricated as necessary. This deficient practice affects all occupants. Findings include: Based on observation with the Environmental Supervisor and the Maintenance Assistant on 09/02/11 at 12:51 p.m., a damper was observed in the ventilation system in the 200 hall mechanical room. Based on interview with the Maintenance Director at the time of observation, there were dampers located throughout the		ensure heating, ventilating, and air conditioning comply with the provisions of section 9.2 and are installed in accordance with the manufacturer's specifications. However, based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · All dampers were inspected and provided necessary maintenance by the Maintenance Director and Maintenance Assistant by October 2, 2011. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken** · All dampers were inspected and provided necessary maintenance by the Maintenance Director and Maintenance Assistant by October 2, 2011. · All residents have the potential to be effected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to**	

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	facility in the ventilation system but the exact number was unknown. He stated the dampers have not been inspected since the building was constructed in 2006. 3.1-19(b)		**ensure that the deficient practice does not recur** · All dampers were inspected and provided necessary maintenance by the Maintenance Director and Maintenance Assistant by October 2, 2011. · All dampers will be added to the preventative maintenance schedule and will be inspected and provided necessary maintenance at least every four years. · The Maintenance Director is in charge of program compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Damper Inspection will be utilized quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI committee. If threshold is not met, an action plan will be developed. • Non-compliance with facility procedures may result in disciplinary action up to and including termination.	

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K0104 SS=F	Penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. Based on observation and interview, the facility fail to ensure 5 of 5 hall duct penetrations were provided with a smoke damper. LSC 101 section 8.3.5.1 states an approved damper designed to resist the passage of smoke shall be provided for each air transfer opening or duct penetration of a required smoke barrier. This deficient practice could affects all occupants. Findings include: Based on observations with the Environmental Supervisor on 09/02/11 from 2:35 p.m. to 2:45 p.m., smoke dampers were not installed in the ventilation duct that penetrated the smoke barrier wall in the 100, 300 and 400 halls. Based on an interview with the Environmental Supervisor at the time of observations, the ventilation duct penetrations of the smoke barrier wall on the 200 and 500 halls would be the same way.	K0104	**Completion date: 10/2/2011** **K 104 NFPA 101 Life Safety Code Standard** It is the practice of this facility to ensure penetrations of smoke barriers by ducts are protected in accordance with 8.3.6. However based on the alleged deficient practice the following has been implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · All penetrations of smoke barriers (100, 200, 300, 400, and 500 Halls) with ducts will be protected by installation of dampers. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · All penetrations of smoke barriers (100, 200, 300, 400, and 500 Halls) with ducts will be protected by installation of dampers. · All residents have the potential to be effected by the alleged deficient practice. **What measures will be put into**	10/02/2011

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	3.1-19(b)		**place or what systemic changes you will make to ensure that the deficient practice does not recur:** · All penetrations of smoke barriers (100, 200, 300, 400, and 500 Halls) with ducts will be protected by installation of dampers. · All new dampers will be added to the preventative maintenance schedule and will be inspected and provided necessary maintenance at least every four years. · Maintenance Director is responsible for program compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Damper Inspection will be utilized quarterly x 2. · Data will be collected by Maintenance Director and submitted to the CQI committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedures may result in disciplinary action up to and including termination. **Completion date: 10/2/2011**	
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786			

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	Based on observation, record review and interview; the facility failed to ensure the care and maintenance of 1 of 1 rolling fire doors was in accordance with NFPA 80. NFPA 80, 1999 Edition, the Standard for Fire Doors and Fire Windows, Section 15-2.4.3 requires all horizontal or vertical sliding and rolling fire doors to be inspected and tested annually to check for proper operation and full closure. Resetting of the release mechanism shall be done in accordance with the manufacturer's instructions. A written record shall be maintained and shall be made available to the authority having jurisdiction. This deficient practice could affect any resident, staff or visitor in the main dining room. Findings include: Based on observation with the Environmental Supervisor and the Maintenance Assistant on 09/02/11 at 2:00 p.m., there was a rolling fire door protecting the opening from the kitchen to the main dining room. The rolling fire door was not in a corridor wall.	K0130	**K 130 NFPA 101 Miscellaneous** It is the practice of this facility to comply with other LSC Deficiency not on 2786. However, based on the alleged deficient practice the following was implemented: **What corrective action(s) will be accomplished for those residents found to have been affected by the deficient practice:** · The rolling door at the kitchen window in the main dining room will be inspected by October 2, 2011 to ensure care and maintenance are in accordance with NFPA 80. **How will you identify other residents having the potential to be affected by the same deficient practice and what corrective action will be taken:** · The rolling door at the kitchen window in the main dining room will be inspected by October 2, 2011 to ensure care and maintenance are in accordance with NFPA 80. · All residents in the main dining room have the potential to be affected by the alleged deficient practice. **What measures will be put into place or what systemic changes you will make to**	10/02/2011

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COVENTRY MEADOWS	7843 W JEFFERSON BLVD FORT WAYNE, IN46804

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Based on interview with the Environmental Supervisor at the time of observation, there has never been an annual inspection or test of the rolling fire door to check for proper operation and full closure. 3.1-19(b)		**ensure that the deficient practice does not recur:** · The rolling door at the kitchen window in the main dining room will be added to the preventative maintenance schedule and will be inspected and provided necessary maintenance on an annual basis. · Maintenance Director is responsible to oversee compliance. **How the corrective action(s) will be monitored to ensure the deficient practice will not recur, i.e., what quality assurance program will be put into place:** · A CQI monitoring tool called Rolling Fire Door will be utilized quarterly x 2. · Data will be collected by Maintenance Director/Designee and submitted to the CQI Committee. If threshold is not met, an action plan will be developed. · Non-compliance with facility procedure may result in disciplinary action up to and including termination. **Compliance date: 10/2/2011**	